



Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: TWELVE OAKS HOSPITAL PO BOX 809053 DALLAS TX 75380-9053	MFDR Tracking #: M4-04-1492-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: AMERICAN GUARANTEE & LIABILITY Box #: 19	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Rationale for Increased Reimbursement: "Carrier rmeitted 1368.00 as reimbursement for outpatient services and relied on Medicare fee guidelines as it foundation. First, the Commission had not adopted said guidelines for the proprocessing of workers comp hospital bills. Second, this provider is not a 'free standing surgical center'. The Texas Admin Code Title 28 part 2, chaopter 134, subsection A 134.1(f) does not set a rate per se regarding reimbursement. It does however state that the reimbursement should be made to reflect what is charges and individual of the same standard of living and or paid by such a person or another acting on that individual's behalf. To that end, this provider hereby submits an explanation of benefit issued by Freeman Administrative Services for the same diagnosis wherein they did make a recommendation at the rate of 80% of the total amount billed. Therefore porovider preys that the commission in its wisdom issue an order for the carrier to reimburse provider at the same rate and inso doing enter an order for additional reimbursement in the amount of \$9,794.00." [sic]

Amount in Dispute: \$9794.00

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The billing in dispute has been paid at a fair and reasonable rate in accordance with TWCC guidelines, policies and rules, and the Texas Labor Code. Carrier has determined that \$1,368.00 represents fair and reasonable reimbursement for this service. Please note that Provider did not submit a copy of the vendor's invoice for the implantables, and therefore, Provider is not entitled to reimbursement. The provider must therefore prove that the reimbursement received is not fair and reasonable."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
2/13/2003	M, N	Outpatient Surgery	\$9794.00	\$0.00
			Total Due:	\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on September 30, 2003. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on October 8, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.

- For the services involved in this dispute, the respondent reduced or denied payment with reason code:
 - M-No MAR.
 - N-Not documented.

- The attached bills have been reviewed in accordance with these policies and are deemed paid in full. Please submit vendor invoices for payment of implants.
2. This dispute relates to outpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that “Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers’ Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission.”
 3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
 4. Division rule at 28 TAC §133.307(g)(3)(C)(iii), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include “how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues.” Review of the submitted documentation finds that the requestor did not state how the Texas Labor Code and Division rules impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iii).
 5. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include “how the submitted documentation supports the requestor position for each disputed fee issue.” Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor’s position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).
 6. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that:
 - The requestor’s rationale for increased reimbursement from the *Table of Disputed Services* states that “Carrier remitted 1368.00 as reimbursement for outpatient services and relied on Medicare fee guidelines as its foundation. First, the Commission had not adopted said guidelines for the processing of workers comp hospital bills. Second, this provider is not a ‘free standing surgical center’. The Texas Admin Code Title 28 part 2, chapter 134, subsection A 134.1(f) does not set a rate per se regarding reimbursement. It does however state that the reimbursement should be made to reflect what is charged and individual of the same standard of living and or paid by such a person or another acting on that individual’s behalf. To that end, this provider hereby submits an explanation of benefit issued by Freeman Administrative Services for the same diagnosis wherein they did make a recommendation at the rate of 80% of the total amount billed. Therefore provider prays that the commission in its wisdom issue an order for the carrier to reimburse provider at the same rate and in so doing enter an order for additional reimbursement in the amount of \$9,794.00.” [sic]
 - In support of the requested reimbursement, the requestor submitted one redacted EOB for services that are similar to the services in dispute. However, the requestor did not discuss or explain how the sample EOB supports the requestor’s position that additional payment is due. The reimbursement methodology is not described on the EOB. Nor did the requestor explain or discuss the sample carriers’ methodology or how the payment amount was determined for the sample EOB. The requestor did not discuss or provide documentation to support whether such payment, as reflected in the sample EOB, was typical for the services in dispute.
 - The requestor does not discuss or explain how payment of 80% of charges would result in a fair and reasonable reimbursement.
 - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
 - The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.
 - The Division has previously found that a reimbursement methodology based upon payment of a hospital’s billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

“A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs,

would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.”

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

7. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(g)(3)(C), and §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

_____	_____	11/04/2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
_____	_____	11/04/2010
Authorized Signature	Medical Fee Dispute Resolution Manager	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.